MISSOURI DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
STATE SCHOOLS FOR SEVERELY HANDICAPPED
P.O. BOX 480
JEFFERSON CITY, MO 65102-0480

MEDICAL STATEMENT FOR STUDENT REQUIRING SPECIAL MEALS

Name of Student:	Date of Birth:
Name of Parent(s):	Telephone:
State School for Severely Handicapped	School Telephone

For Completion By Physician (M.D. or D. O. only):

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet.

Diet Prescription (Check all that apply):

☐ Diabetic (include calorie level or attach meal plan ☐ Modified Texture and/or Liquids
☐ Reduced Calorie ☐ Food Allergy (describe):
☐ Increased Calorie ☐ Other (describe):

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ Special Feeding Equipment _____

Additional Comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature (M.D. or D.O. only)	**Telephone Number**	**Date**
Physician's Name (Print)	**Physician's Address**	

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Signature of Parent	Date